Brookhaven Science Associates, LLC.

CIGNA DENTAL PREFERRED PROVIDER INSURANCE

SCSPA Union

EFFECTIVE DATE: January 1, 2005

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This document printed in September, 2005 takes the place of any documents previously issued to you which described your benefits.

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Important Information About Your Dental Plan

When you elected Dental Insurance for yourself and your Dependents, you elected one of the two options offered:

- **CIGNA Dental Care; or**
- **CIGNA Dental Preferred Provider.**

Details of the benefits under each of the options are described in separate certificates/booklets.

When electing an option initially or when changing options as described below, the following rules apply:

- **You and your Dependents may enroll for only one of the options, not for both options.**
- **Your Dependents will be insured only if you are insured and only for the same option.**

Change in Option Elected:

You may elect to change options for yourself and your Dependents during any Open Enrollment Period.

In addition, if you and your Dependents are insured under CIGNA Dental Care, you may elect to transfer to CIGNA Dental Preferred Provider at any time if: (1) you relocate outside the Provider Organization's service area, or (2) you are deemed to be terminated for breakdown in the patient/doctor relationship under CIGNA Dental Care, as determined by the Provider Organization.

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Effective Date of Change In Option:

Follow your Employer's guidelines to change your dental option at enrollment. Your Employer may require a new enrollment form for the option you elect. If you elect a change in your dental option, the effective date of the change in option is as follows:

If you are changing options during an Open Enrollment Period, you and your Dependents will become insured for the option elected on your Employer's effective date of the plan year.

If you are transferring from CIGNA Dental Care to CIGNA Dental Preferred Provider due to relocation or termination for ineligibility for the In-Network Plan, you and your Dependents will become insured for the CIGNA Dental Preferred Provider on the first day of the month following the processed transfer.

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Notice Regarding Provider Directories and Provider Networks

If your Plan utilizes a network of Providers, you will automatically and without charge, receive a separate listing of Participating Providers. You may also visit the CIGNA website for a list of Providers at www.CIGNA.com.

Your Participating Provider network consists of a group of local dental practitioners, of varied specialties as well as general practice, who are employed by or contracted with CIGNA HealthCare or CIGNA Dental Health.

NOT86 M

Notice of Federal Requirements Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short-term or Long-term Disability or Accidental Death & Dismemberment coverage.

Continuation of Coverage

For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.

For leaves of 31 days or more, you may continue coverage for yourself and your Dependent as follows:

You may continue benefits, by paying the required premium to your Employer, until the earliest of the following:

- 24 months from the last day of employment with the Employer;
- the day after you fail to apply or return to work; and
- the date the policy cancels.

Your Employer may charge you and your Dependents up to 102% of the total premium.

Following continuation of health coverage per USERRA requirements, you may convert to a plan of individual coverage according to any "Conversion Privilege" shown in your certificate.

NOT141

Reinstatement of Benefits (applicable to all coverages)

If your coverage ends during the leave because you do not elect USERRA or an available conversion plan at the

expiration of USERRA and you are reemployed by your current Employer, coverage for you and your Dependents may be reinstated if, (a) you gave your Employer advance written or verbal notice of your military service leave, and (b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

You and your Dependents will be subject to only the balance of a Pre-existing Condition Limitation (PCL) or waiting period that was not yet satisfied before the leave began. However, if an Injury or Sickness occurs or is aggravated during the military leave, full Plan limitations will apply.

Any 63-day break in coverage rule regarding credit for time accrued toward a PCL waiting period will be waived.

NOT142

Notice of Federal Requirements

If your income does not exceed 100% of the official poverty line and your liquid resources are at or below twice the Social Security income level, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost-effective. This includes premiums for continuation coverage required by federal law.

NOT99

Important Information

THIS IS NOT AN INSURED BENEFIT PLAN. THE BENEFITS DESCRIBED IN THIS BOOKLET OR ANY RIDER ATTACHED HERETO ARE SELF-INSURED BY BROOKHAVEN SCIENCE ASSOCIATES, LLC. WHICH IS RESPONSIBLE FOR THEIR PAYMENT. CONNECTICUT GENERAL PROVIDES CLAIM ADMINISTRATION SERVICES TO THE PLAN, BUT CONNECTICUT GENERAL DOES NOT INSURE THE BENEFITS DESCRIBED.

THIS DOCUMENT MAY USE WORDS THAT DESCRIBE A PLAN INSURED BY CONNECTICUT GENERAL. BECAUSE THE PLAN IS NOT INSURED BY CONNECTICUT GENERAL, ALL REFERENCES TO INSURANCE SHALL BE READ TO INDICATE THAT THE PLAN IS SELF-INSURED. FOR EXAMPLE, REFERENCES TO "CG," "INSURANCE COMPANY," AND "POLICYHOLDER" SHALL BE DEEMED TO MEAN YOUR "EMPLOYER" AND "POLICY" TO MEAN "PLAN" AND "INSURED" TO MEAN "COVERED" AND "INSURANCE" SHALL BE DEEMED TO MEAN "COVERAGE."

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Explanation of Terms

You will find terms starting with capital letters throughout your certificate. To help you understand your benefits, most of these terms are defined in the Definitions section of your certificate.

THE SCHEDULE

The Schedule is a brief outline of your maximum benefits which may be payable under your insurance. For a full description of each benefit, refer to the appropriate section listed in the Table of Contents.

Effect of Section 125 Regulations on this Plan

Your Employer has chosen to administer this Plan in accordance with Section 125 Regulations of the Internal Revenue Code. Per this regulation, you may agree to a pre-tax salary reduction put toward the cost of your benefits. Otherwise you will receive your taxable earnings as cash (salary).

Provisions in this certificate which allow for enrollment or coverage changes not consistent with Section 125 Regulations are superseded by this section.

Coverage Elections

Per Section 125 Regulations, you are generally allowed to enroll for or change coverage only before each annual benefit period. However, exceptions are allowed if you enroll for or change coverage within 30 days of the following:

- the date you meet Special Enrollment criteria per federal requirements as described in the Section entitled "Eligibility - Effective Date/Exception to Late Entrant Definition"; or
- the date you meet the criteria shown in the section entitled "Change of Status."

SCT125V1

Change in Status

A change in status is defined as:

(a) change in legal marital status due to marriage, death of a spouse, divorce, annulment or legal separation;

(b) change in number of dependents due to birth, adoption, placement for adoption or death of a dependent;

(c) change in employment status of Employee, spouse or dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under Family and Medical Leave Act (FMLA) or change in worksite;

(d) changes in employment status of Employee, spouse or dependent resulting in eligibility or ineligibility for coverage;

(e) change in residence of Employee, spouse or dependent; and

(f) changes which cause a dependent to become eligible or ineligible for coverage.

Any changes in coverage must pertain directly to the change in status.

Court Order

A change in coverage due to and consistent with a court order of the Employee or other person to cover a Dependent.

Medicare Eligibility/Entitlement

The Employee, spouse or Dependent cancels or reduces coverage due to entitlement to Medicare, or enrolls or increases coverage due to loss of Medicare eligibility.

Change in Cost of Coverage

If the cost of benefits increases or decreases during a benefit period, your Employer may in accordance with plan terms automatically change your elective contribution.

When the change in cost is significant, you may either increase your contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option you have elected, you may elect another available benefit option. When a new benefit option is added, you may change your election to the new benefit option.

Changes in Coverage of Spouse or Dependent Under Another Employer's Plan

You may make a coverage election change if the plan of your spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare Eligibility/Entitlement; or (c) this Plan and the other plan have different periods of coverage.

SCT125V2

How to File Your Claim

The prompt filing of any required claim form will result in faster payment of your claim.

You may get the required claim forms from your Benefit Plan Administrator. All fully completed claim forms and bills should be sent directly to your servicing CG Claim Office.

Dental Expenses

The first Dental Claim should be filed as soon as you have incurred covered expenses. Itemized copies of your bills should be sent with the claim form. If you have any additional bills after the first treatment, file them periodically.

You must follow the Predetermination of Benefits procedure when it is necessary for dental forms.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CG'S CLAIM

FORMS, OR WHEN YOU CALL YOUR CG CLAIM OFFICE:

YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

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Accident and Health Provisions

Notice of Claim

Written notice of claim must be given to CG within 30 days after the occurrence or start of the loss on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

Claim Forms

When CG receives the notice of claim, it will give to the claimant, or to the Employer for the claimant, the claim forms which it uses for filing proof of loss. If the claimant does not get these claim forms within 15 days after CG receives notice of claim, he will be considered to meet the proof of loss requirements if he submits written proof of loss within 90 days after the date of loss. This proof must describe the occurrence, character and extent of the loss for which claim is made.

Proof of Loss

Written proof of loss must be given to CG within 90 days after the date of the loss for which claim is made. If written proof of loss is not given in that time, the claim will not be invalidated or reduced if it is shown that written proof of loss was given as soon as was reasonably possible.

Physical Examination

The Employer, at its own expense, will have the right to examine any person for whom claim is pending as often as it may reasonably require.

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Eligibility - Effective Date

Eligibility for Employee Insurance

You will become eligible for insurance on the day you complete the waiting period if:

- you are in a Class of Eligible Employees; and
- you are an eligible, full-time Employee; and
- you normally work at least 20 hours a week.

If you were previously insured and your insurance ceased, you must satisfy the New Employee Group Waiting Period to become insured again. If your insurance ceased because you were no longer employed in a Class of Eligible Employees, you are not required to satisfy any waiting period if you again become a member of a Class of Eligible Employees within one year after your insurance ceased.

Initial Employee Group: You are in the Initial Employee Group if you are employed in a class of employees on the date that class of employees becomes a Class of Eligible Employees as determined by your Employer.

New Employee Group: You are in the New Employee Group if you are not in the Initial Employee Group.

Eligibility for Dependent Insurance

You will become eligible for Dependent insurance on the later of:

- the day you become eligible for yourself; or
- the day you acquire your first Dependent.

Waiting Period

Initial Employee Group: None

New Employee Group: None

Classes of Eligible Employees

Each Employee and participant receiving long term disability benefits as reported to the insurance company by your Employer.

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ELI5 DG

Employee Insurance

This plan is offered to you as an Employee. To be insured, you will have to pay part of the cost.

Effective Date of Your Insurance

You will become insured on the date you elect the insurance by signing an approved payroll deduction form, but no earlier than the date you become eligible.

You will become insured on your first day of eligibility, following your election, if you are in Active Service on the date, or if you are not in Active Service on that date due to your health status.

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Dependent Insurance

For your Dependents to be insured, you will have to pay part of the cost of Dependent Insurance.

Effective Date of Dependent Insurance

Insurance for your Dependents will become effective on the date you elect it by signing an approved payroll deduction form, but no earlier than the day you become eligible for Dependent Insurance. All of your Dependents as defined will be included.

Your Dependents will be insured only if you are insured.

GM6000 EF 2 ELI10 M

Requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

These health coverage requirements do not apply to any benefits for loss of life, dismemberment or loss of income.

Any other provisions in this certificate that provide for: (a) the definition of an adopted child and the effective date of eligibility for coverage of that child; and (b) eligibility requirements for a child for whom a court order for medical support is issued; are superseded by these provisions required by the federal Omnibus Budget Reconciliation Act of 1993, where applicable.

A. Eligibility for Coverage Under a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order is issued for your child, that child will be eligible for coverage as required by the order and you will not be considered a Late Entrant for Dependent Insurance.

You must notify your Employer and elect coverage for that child, and yourself if you are not already enrolled, within 31 days of the Qualified Medical Child Support Order being issued.

Qualified Medical Child Support Order

A Qualified Medical Child Support Order is a judgment, decree or order (including approval of a settlement agreement) or administrative notice, which is issued pursuant to a state domestic relations law (including a community property law), or to an administrative process, which provides for child support or provides for health benefit coverage to such child and relates to benefits under the group health plan, and satisfies all of the following:

1. the order recognizes or creates a child's right to receive group health benefits for which a participant or beneficiary is eligible;
2. the order specifies your name and last known address, and the child's name and last known address, except that the name and address of an official of a state or political subdivision may be substituted for the child's mailing address;
3. the order provides a description of the coverage to be provided, or the manner in which the type of coverage is to be determined;
4. the order states the period to which it applies; and
5. if the order is a National Medical Support Notice completed in accordance with the Child Support Performance and Incentive Act of 1998, such Notice meets the requirements above.

OBRA1

The Qualified Medical Child Support Order may not require the health insurance policy to provide coverage for any type or form of benefit or option not otherwise provided under the policy, except an order may require a plan to comply with State laws regarding child health care coverage.

Payment of Benefits

Any payment of benefits in reimbursement for Covered Expenses paid by the child, the child's custodial parent or legal guardian, shall be made to the child, the child's custodial parent or legal guardian, or a State official whose name and address have been substituted for the name and address of the child.

B. Eligibility for Coverage for Adopted Children

Any child under the age of 18 who is adopted by you, including a child who is placed with you for adoption, will be eligible for Dependent Insurance upon the date of placement with you. A child will be considered placed for adoption when you become legally obligated to support that child, totally or partially, prior to that child's adoption.

If a child placed for adoption is not adopted, all health coverage ceases when the placement ends, and will not be continued.

OBRA4

CIGNA Dental Preferred Provider Benefits

The Schedule

The Dental Benefits Plan offered by your Employer includes two options. When you select a Participating Provider, this plan pays a greater share of the cost than if you were to select a Non-Participating Provider.

For You and Your Dependents

Emergency Services

The Benefit Percentage for Emergency Services incurred for charges made by a Non-Participating Provider is the same Benefit Percentage as for Participating Provider Charges. Dental Emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

HOW YOUR DENTAL PLAN WORKS

PARTICIPATING PROVIDER:

<table>
<tr><td>Class I
Preventive Care</td><td colspan="2">Plan Pays 80%
There is no Deductible</td></tr>
<tr><td>Class II
Basic Restorative</td><td rowspan="2">You or Your Dependent pays $25 Deductible</td><td>Plan Pays 60%</td></tr>
<tr><td>Class III
Major Restorative</td><td>Plan Pays 50%</td></tr>
<tr><td>Class IV
Orthodontia</td><td colspan="2">Plan Pays 50%
There is no Deductible</td></tr>
</table>

Class IV Orthodontia applies only to a Dependent Child less than 25 years of age.

NON-PARTICIPATING PROVIDER:

<table>
<tr><td>Class I
Preventive Care</td><td colspan="2">Plan Pays 70%
There is no Deductible</td></tr>
<tr><td>Class II
Basic Restorative</td><td rowspan="2">You or Your Dependent pays $25 Deductible</td><td>Plan Pays 45%</td></tr>
<tr><td>Class III
Major Restorative</td><td>Plan Pays 35%</td></tr>
<tr><td>Class IV
Orthodontia</td><td colspan="2">Plan Pays 50%
There is no Deductible</td></tr>
</table>

Class IV Orthodontia applies only to a Dependent Child less than 25 years of age.

Maximum Benefit

Combined Participating Provider and Non-Participating Provider Classes I, II, III Calendar Year Maximum	$1,000
Combined Participating Provider and Non-Participating Provider Class IV Lifetime Maximum	$1,000

Deductibles

The deductibles listed below are expenses to be paid by an Employee or Dependent for the services rendered. These Deductibles are in addition to any other expenses, incurred for which no benefits are payable because of a coinsurance factor:

Individual Deductible A person must satisfy this deductible amount for each calendar year before Dental Benefits are payable.	$25
Family Deductible After Dental Deductibles totaling $75 have been applied in a calendar year for either (a) you and your Dependents; or (b) your Dependents, your family need not satisfy any further Dental Deductibles for the rest of the year.	$75

Covered Expenses

The term Covered Expenses means expenses incurred by or on behalf of you or any one of your Dependents for charges made by a Dentist for the performance of a Dental Service listed in the Dental Services Schedule.

Covered Expenses will include only those expenses incurred for such charges when the Dental Service:

- is performed by or under the direction of a Dentist;
- is essential for the necessary care of the teeth; and
- starts and is completed while the person is insured.

Any portion of charges for a Dental Service that exceeds the Maximum Covered Expense shown for that service in the Dental Services Schedule is not included.

A Dental Service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared.
- for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved.
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

Alternate Benefit Provision

When more than one covered Dental Service could provide suitable treatment based on common dental standards, CG will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. You and your Dentist are free to apply this benefit payment to the treatment of your choice; however, you are responsible for the expenses incurred which exceed Covered Expenses. For this reason, CG strongly recommends the use of predetermination of benefits when major dental services are needed, so that you and your Dentist know in advance what the benefit plan will cover before any treatment begins.

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Predetermination of Benefits

The term Predetermination of Benefits means a review by CG of a Dentist's description of planned treatment and expected charges, including those for diagnostic x-rays. This review should be made whenever extensive dental work is proposed. The information should be sent to CG before the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to CG.

The expenses that will be included as Covered Expenses will be determined by CG and are subject to the Alternate Benefit Provision. When there has not been a Predetermination of Benefits, CG will determine the expenses that will be included as Covered Expenses at the time the claim is received.

Predetermination of Benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

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Dental Benefits - CIGNA Dental Preferred Provider

For You and Your Dependents

If you or any one of your Dependents incurs Covered Expenses, CG will:

- deduct any Dental Deductible that applies from the Covered Expenses first incurred in a calendar year for a person; and
- pay for the other Covered Expenses incurred in that calendar year up to the Maximum Covered Expense determined from the Dental Services Schedule for each Dental Service subject to the Alternate Benefit Provision.

The Dental Deductible is shown in The Schedule.

Missing Teeth Limit

The amount payable is 50% of the amount otherwise payable for first replacement of teeth that are missing when a person becomes insured for these benefits.

After a person has been continuously insured for these benefits for 24 months, this limit will no longer apply.

The Missing Teeth Limit will not apply to any person who is a member of the Initial Employee Group.

Orthodontia Provision

The total amount payable for all expenses incurred for Orthodontics for a Dependent child less than 25 years of age during his lifetime will not be more than the Orthodontia Maximum shown in The Schedule.

Payments for Comprehensive Full-Banded Orthodontic Treatments are made in installments. Payment of benefits will be made every 3 months. The first payment becomes payable when the appliance is installed. Later payments are payable at the end of each 3-month period. In determining the first installment, CG assigns 25% of the charge for the entire course of treatment to the appliance. The rest of such charge is prorated over the estimated duration of such treatment. These payments are made only for services

performed while such child is insured. If insurance or treatment on such child ceases, the amount payable for that 3 month period will be prorated.

Maximum Benefit Provision

The total amount payable for all expenses for other than Orthodontics incurred for a person in a calendar year will not be more than the Maximum Benefit shown in The Schedule.

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Dental Services Schedule

Covered Dental Expenses will include expenses incurred for Dental Services listed in this Schedule. CG may agree to accept, as Covered Dental Expenses, expenses for services not listed. To be considered, services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by description and should be submitted to CG.

If you or any one of your Dependents, while insured for these benefits, incurs Covered Dental Expenses, CG will pay any amount determined as follows:

> The Maximum Covered Expense for any covered service received from a Participating Provider is the Contracted Fee Amount subject to the Benefit Percentage for Participating Providers shown on the Schedule for each class of service. The Maximum Covered Expense for any covered service received from a non-Participating Provider is the Reasonable and Customary charge subject to the Benefit Percentage for non-Participating Providers shown in The Schedule for each class of service. The insured must pay the balance up to the non-Participating Provider's actual charge.

Payment of any benefits will be subject to any applicable deductibles and maximum benefits shown in The Schedule.

A temporary Dental Service is included in the allowance for the final Dental Service and is not a separate Dental Service.

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Class I Services - Diagnostic and Preventive

Clinical oral examination - Only two per person per calendar year.

Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive Dental Services are performed. (Any x-ray taken in connection with such treatment is a separate Dental Service.)

X-rays - Complete series - Only one per person, including panoramic film, in any 3 calendar years.

Bitewing x-rays - Only two charges per person per calendar year.

Panoramic (Panorex) x-ray - Only one per person in any 3 calendar years.

Prophylaxis (Cleaning) - Only two per person per calendar year.

Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.

Topical application of fluoride (excluding prophylaxis) - Limited to persons less than 19 years old. Only one per person per calendar year.

Topical application of sealant, per tooth, on a posterior tooth for a person less than 14 years old - Only one treatment per tooth in any 3 calendar years.

Space Maintainers, fixed unilateral - Limited to non-orthodontic treatment.

GM6000 DES297

Class II Services - Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

Amalgam Filling - One Surface

Composite/Resin Filling, One Surface

Root Canal Therapy - Any x-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate Dental Service.

Osseous Surgery - Flap entry and closure is part of the allowance for osseous surgery and osseous graft and not a separate Dental Service.

If more than one periodontal surgical service is performed per quadrant only the one with the largest Maximum Covered Expense is a Dental Service.

Periodontal Scaling and Root Planing - Entire Mouth

Adjustments - Complete Denture

Any adjustment of or repair to a denture within 6 months of its installation is not a separate Dental Service.

Recement Bridge

Routine Extractions

Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone and/or Section of Tooth

> Removal of Impacted Tooth, Soft Tissue
>
> Removal of Impacted Tooth, Partially Bony
>
> Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine postoperative care for extractions and other oral surgery are part of the allowance for each Dental Service.

General Anesthesia - Paid as a separate benefit only when Medically or Dentally Necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

I. V. Sedation - Paid as a separate benefit only when Medically or Dentally Necessary, as determined by CG, and when administered in conjunction with complex oral surgical procedures which are covered under this plan.

GM6000 DES298 V4

Class III Services - Major Restorations, Dentures and Bridgework

High Noble Metal (gold) or Crown restorations are Dental Services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.

Crowns

Porcelain Fused to High Noble Metal

Full Cast, High Noble Metal

Three-Fourths Cast, Metallic

Fixed or Removable Appliances

Complete (Full) Dentures, Upper or Lower

Partial Dentures

Lower, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Upper, Cast Metal Base with Resin Saddles (including any conventional clasps, rests and teeth)

Bridge Pontics - Cast High Noble Metal

Bridge Pontics - Porcelain Fused to High Noble Metal

Bridge Pontics - Resin with High Noble Metal

Retainer Crowns - Resin with High Noble Metal

Retainer Crowns - Porcelain Fused to High Noble Metal

Retainer Crowns - Full Cast Gold

Class IV Services - Orthodontics

Each month of active treatment is a separate Dental Service.

Orthodontic work-up including x-rays, diagnostic casts and treatment plan and the first month of active treatment including all active treatment and retention appliances.

Active treatment per month after the first month.

Fixed or Removable Appliances – Only one appliance per person

For Tooth Guidance

To Control Harmful Habits

GM6000 DES299 V1

Expenses Not Covered

Covered Expenses will not include, and no payment will be made for, expenses incurred for:

- services performed solely for cosmetic reasons;
- replacement of a lost or stolen appliance;
- replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;
- any replacement of a bridge, crown or denture which is or can be made useable according to common dental standards;
- procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;
- orthodontic services or supplies for any person other than a Dependent child less than 25 years of age;
- porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars;
- bite registrations; precision or semiprecision attachments; or splinting;

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DEN16V9

- a surgical implant of any type including any prosthetic device attached to it;
- instruction for plaque control, oral hygiene and diet;
- dental services that do not meet common dental standards;
- services that are deemed to be medical services;
- services and supplies received from a Hospital;
- services for which benefits are not payable according to the "General Limitations" section.

In addition, these benefits will be reduced so that the total payment under the items below will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under:

- this plan; and
- any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

GM6000 DE6 DEN23V5

General Limitations

Dental Benefits

No payment will be made for expenses incurred for you or any one of your Dependents:

- for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
- for or in connection with a Sickness which is covered under any workers' compensation or similar law;
- for charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
- services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
- to the extent that payment is unlawful where the person resides when the expenses are incurred;
- for charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- to the extent that billed charges exceed the rate of reimbursement as described in the Schedule;
- for charges for unnecessary care, treatment or surgery;
- to the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

GM6000 GEN312 V4

No payment will be made for expenses incurred by you or any one of your Dependents to the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with:

- a "no-fault" insurance law; or
- an uninsured motorist insurance law.

CG will take into account any adjustment option chosen under such part by you or any one of your Dependents.

GM6000 GL3 GEN153V11

Coordination of Benefits

If you or any one of your Dependents is covered under more than one Plan, benefits payable from all such Plans will be coordinated.

Coordination of Benefits will be used to determine the benefits payable for a person for any Claim Determination Period if, for the Allowable Expenses incurred in that Period, the sum of:

(a) the benefits that would be payable from this Plan in the absence of coordination; and

(b) the benefits that would be payable from all other Plans without Coordination of Benefits provisions in those Plans;

would exceed such Allowable Expenses.

The benefits that would be payable from this Plan for Allowable Expenses incurred in any Claim Determination Period in the absence of Coordination of Benefits will be reduced to the extent required so that the sum of:

(a) those reduced benefits; and

(b) all the benefits payable for those Allowable Expenses from all other Plans;

will not exceed the total of such Allowable Expenses. Benefits payable from all other Plans include the benefits that would have been payable had proper claim been made for them.

However, the benefits of another Plan will be ignored when the benefits of this Plan are determined if: (a) the Benefit Determination Rules would require this Plan to determine its benefits before that Plan; and (b) the other Plan has a provision that coordinates its benefits with those of this Plan and would, based on its rules, determine its benefits after this Plan.

GM6000 CB7 V-1
COR14

CG reserves the right to release to or obtain from any other Insurance Company or other organization or person any information which, in its opinion, it needs for the purpose of Coordination of Benefits.

When payments which should have been made under this Plan based on the terms of this section have been made under any other Plans, CG will have the right to pay to any organizations making these payments the amount it determines to be warranted. Amounts paid in this manner will be considered to be benefits paid under this Plan. CG will be released from all liability under this Plan to the extent of these payments. When an overpayment has been made by CG at any time, it will have the right to recover that payment, to the extent of the excess, from the person to whom it was made or any other Insurance Company or organization, as it may determine.

Plan

Plan means any of the following which provides dental benefits or services: (a) group, blanket or franchise insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any: labor-management trusteed plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Allowable Expense

Allowable Expense means any necessary, reasonable and customary item of expense, at least a part of which is covered by any one of the Plans that covers the person for whom claim is made. When the benefits from a Plan are in the form of services, not cash payments, the reasonable cash value of each service is both an Allowable Expense and a benefit paid.

Claim Determination Period

Claim Determination Period means a calendar year or that part of a calendar year in which the person has been covered under this Plan.

GM6000 CB9
GM6000 CB10 (1)
COR23 DG

Benefit Determination Rules

The rules below establish the order in which benefits will be determined:

1. The benefits of a Plan which covers the person for whom claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.
2. The benefits of a Plan which covers the person for whom claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person as a dependent of a person whose day of birth occurs later in that year; except that: (a) if the other Plan does not have this rule, its alternate rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.
3. If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the Plan which covers the child as a dependent of the parent so responsible will be determined before any other plan; otherwise:
   a. The benefits of a Plan which covers the child as a dependent of the parent with custody will be determined before a Plan which covers the child as a dependent of a stepparent or a parent without custody.
   b. The benefits of a Plan which covers the child as a dependent of a stepparent will be determined before a plan which covers the child as a dependent of the parent without custody.

GM6000 CB10 (2)
COR33

(4) When the above rules do not establish the order, the benefits of a plan which has covered the person for whom claim is made for the longer period of time will be determined before a Plan which has covered the person for the shorter period of time; except that:
   (a) The benefits of a Plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a Plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.
   (b) If the other Plan does not have the rule in item (4)(a), which results in each Plan determining its benefits after the other, then item (4)(a) will not apply.

GM6000 CB11 COR35

Right of Reimbursement

The Policy does not cover:

(1) Expenses for which another party may be responsible as a result of liability for causing or contributing to the injury or illness of you or your Dependent(s).

(2) Expenses to the extent they are covered under the terms of any automobile medical, automobile no fault, uninsured or underinsured motorist, workers' compensation, government insurance, other than Medicaid, or similar type of insurance or coverage when insurance coverage provides benefits on behalf of you or your Dependent(s).

If you or a Dependent incur health care Expenses as described in (1) and (2) above, Connecticut General shall automatically have a lien upon the proceeds of any recovery by you or your Dependent(s) from such party to the extent of any benefits provided to you or your Dependent(s) by the Policy. You or your Dependent(s) or their representative shall execute such documents as may be required to secure Connecticut General's rights. Connecticut General shall be reimbursed the lesser of:

the amount actually paid by CG (or the HealthPlan) under the Policy; or

an amount actually received from the third party;

at the time that the third party's liability is determined and satisfied; whether by settlement, judgment, arbitration or otherwise.

GM6000 CCP1 CCL1V4

Payment of Benefits

To Whom Payable

All Dental Benefits are payable to you. However, at the option of CG and with the consent of the Policyholder, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

If any person to whom benefits are payable is a minor or, in the opinion of CG, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CG may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CG may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CG from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by CG when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by CG, CG will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

GM6000 POB12 PMT135V16

Termination of Insurance

Termination of Insurance - Employees

Your insurance will cease on the earliest date below:

- the date you cease to be in a Class of Eligible Employees or cease to qualify for the insurance.
- the last day for which you have made any required contribution for the insurance.
- the date the policy is canceled.
- the date your Active Service ends except as described below.

Any continuation of insurance must be based on a plan which precludes individual selection.

Temporary Layoff or Leave of Absence

If your Active Service ends due to temporary layoff or leave of absence, your insurance will be continued until the date your Employer: (a) stops paying premium for you; or (b) otherwise cancels your insurance. However, your insurance will not be continued for more than 60 days past the date your Active Service ends.

Injury or Sickness

If your Active Service ends due to an Injury or Sickness, your insurance will be continued while you remain totally and continuously disabled as a result of the Injury or Sickness. However, the insurance will not continue past the date your Employer stops paying premium for you or otherwise cancels the insurance.

Retirement

If your Active Service ends because you retire, your insurance will be continued until the date on which your Employer stops paying premium for you or otherwise cancels the insurance.

GM6000 TRM15V44

Termination of Insurance - Dependents

Your insurance for all of your Dependents will cease on the earliest date below:

- the date your insurance ceases.
- the date you cease to be eligible for Dependent Insurance.
- the last day for which you have made any required contribution for the insurance.
- the date Dependent Insurance is canceled.

The insurance for any one of your Dependents will cease on the date that Dependent no longer qualifies as a Dependent.

GM6000 TRM309

Continuation Required by Federal Law For You and Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income.

Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than for gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of

your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

A. Employees and Dependents Continuation Provision

If you and your Dependent's insurance would otherwise cease because of a reduction in the number of hours you work or your termination of employment for any reason other than gross misconduct, you or your Dependent may continue health insurance upon payment of the required premium to the Employer. You and your Dependents must elect to continue insurance within 60 days from the later of: (a) the date of a reduction of your work hours or your termination of employment; (b) the date notice of the right to continue insurance is sent; or (c) the date the insurance would otherwise cease. You must pay the first premium within 45 days from the date you elect to continue coverage. Such insurance will not be continued by CG for you and/or your Dependents, as applicable, beyond the earliest of the following dates:

- 18 months from the date your work hours are reduced or your employment terminates, whichever may occur first;
- the date the policy cancels;
- the date coverage ends due to your failure to pay the required subsequent premium within 30 days of the due date;
- the date your Dependent ceases to qualify as an eligible Dependent;
- after you elect to continue this insurance, the date you first become entitled to Medicare, and for your Dependent, the date he first becomes entitled to Medicare;
- after you elect to continue this insurance, for you, the date you first become covered under another group health plan, unless you have a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

B. Dependent Continuation Provision

If health insurance for your Dependents would otherwise cease because of:

(1) your death;

(2) divorce or legal separation; or

(3) with respect to a Dependent child, failure to continue to qualify as a Dependent,

such insurance may be continued upon payment of the required premium to the Employer. In the case of (2) or (3) above, you or your Dependent must notify your Employer within 60 days of such event. In addition, a Dependent must elect to continue insurance within 60 days from the later of: (a) the date the insurance would otherwise cease; or (b) the date notice of the right to continue insurance is sent.

CG will not continue the health insurance of a Dependent beyond the earliest of the following dates:

- 36 months from the date of (1), (2) or (3) above, whichever may occur first;
- the date coverage ends due to failure to pay the required subsequent premium within 30 days of the due date;
- after the Dependent elects to continue this insurance, the date the Dependent first becomes entitled to Medicare;
- the date the policy cancels; or
- after the Dependent elects to continue this insurance, the date the Dependent first becomes covered under another group health plan, unless the Dependent has a condition for which the new plan limits or excludes coverage, in which case coverage will continue until the earliest of any other point above.

C. Subsequent Events Affecting Dependent Coverage

If, within the initial 18-month continuation period, your Dependent would lose coverage because of an event described in (1), (2), or (3) of Section B, or because of your coverage loss due to your subsequent entitlement to Medicare, after you have continued your Dependent's coverage due to your employment termination or reduction in work hours, your Dependent may continue coverage for up to 36 months from the date of loss of employment or reduction in work hours.

If your employment ends or your work hours are reduced within 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 36 months from the date you become entitled to Medicare.

If your employment ends or your work hours are reduced more than 18 months after your entitlement to Medicare, your covered Dependent may continue coverage for up to 18 months from the date your employment ends or your work hours are reduced.

Disabled Individuals Continuation Provisions

If you or your Dependent is disabled before or within the first 60 days of continuation of coverage which follow termination of employment or a reduction in work hours, the disabled person may continue health insurance for up to an additional 11 months beyond the 18-month period.

If you or your Dependents who are not disabled elect to continue coverage, such family members of the disabled person may extend coverage for up to an additional 11 months, if they otherwise remain eligible, and notice of disability is provided as described in (b), below.

To be eligible you or your Dependent must:

(a) be declared disabled as of a day before or during the first 60 days of continuation, under Title II or XVI by the Social Security Administration; and

(b) notify the plan administrator of the Social Security Administration's determination within 60 days following the determination and within the initial 18-month continuation period, and provide the Plan Administrator with a copy of the determination.

Termination of coverage for all covered persons during the additional 11 months will occur if the disabled person is found by the Social Security Administration to be no longer disabled. Termination for this reason will occur on the first day of the month beginning more than 30 days after the date of the final determination.

All reasons for termination described in sections A and B which apply to the initial 18 months will also apply to any or all covered persons for any additional months of coverage.

COBRA4

D. Effect of Employer Chapter 11 Proceedings on Retiree Coverage

If you are covered as a retiree, and a proceeding under USC Chapter 11, bankruptcy for the Employer results in a substantial loss of coverage for you or your Dependents within one year before or after such proceeding, coverage will continue until: a. for you, your death; and b. for your Dependent surviving spouse or Dependent child, up to 36 months from your death.

COBRA15

E. Payment of Premium

This Plan may require the payment of an amount that does not exceed 102% of the applicable premium, except this Plan may require payment of up to 150% of the Applicable Premium for any extended period of continuation coverage for a covered person who is disabled. The additional 48% may only be applied to the premium for the rating category that includes the disabled individual, and only for the additional 11 months.

Applicable Premium is determined as follows:

1. if the Employee alone elects to continue coverage, the Employee will be charged the active Employee rate;
2. if a Dependent spouse alone elects to continue coverage, the spouse will be charged the active Employee rate;
3. if a Dependent child or children elect to continue coverage without a parent also electing the continuation, each child will be charged the active Employee rate;
4. if the entire family elects to continue coverage, they will be charged the family rate;
5. if the Schedule of Premium rates is set up on a step-rate basis, the active rate basis that fits the individuals who elect to continue their coverage is the rate that will be charged. If only children elect to continue coverage, each child will be charged the Employee Only rate.

Timely Payment

If Payment is made within the grace period in an amount not significantly less than the amount the Plan requires to be paid, the amount must be deemed to satisfy the Plan's requirement. However, you must be notified and allowed at least 30 days after notice is provided for payment to be made.

F. Providing Notification of Your Status to Health Care Providers During the Grace Period

If, after you elect to continue coverage, a health care provider contacts this Plan to confirm coverage for a period for which premium has not yet been received, the Plan must give a complete and accurate response.

COBRA17

G. Notification Requirements

Your Employer should send you initial notification of coverage continuation rights as required by federal law; (a) when the Plan first becomes subject to federal continuation requirements; (b) when you are hired; and (c) when you add a spouse as a Dependent for benefits under the Plan. Receipt of this certificate may serve as such notice.

If you become eligible to continue coverage per federal law, your Employer must send you notification within 14 days. If the Plan has a Plan Administrator, the Employer must notify the Plan Administrator within 30 days. The Plan Administrator must notify you within 14 days, thereafter.

If eligibility to continue coverage is due to divorce, legal separation or a Dependent child losing eligibility for coverage under the Plan, you or your Dependent spouse must notify your Employer within 60 days of such event. Your Employer must notify you of the right to continue coverage within 14 days after receipt of notification of such event.

COBRA18

Interaction With Other Continuation Benefits

A person who is eligible to continue insurance under both (1) and (2) below may continue the insurance, upon payment of any required premium, for a period of time not to exceed the longer of: (1) the continuation required by federal law; or (2) any other continuation of insurance provided in this Certificate.

Newly Acquired Dependents

If, while your insurance is being continued under the continuation required by federal law provisions, you acquire a new Dependent, such Dependent will be eligible for this Continuation provided:

- the required premium is paid; and
- CG is notified of your newly acquired Dependent in accordance with the terms of the policy.

If events 1 or 2 of Section B should subsequently occur for your newly acquired Dependent spouse, such spouse will not be entitled to continue his insurance. However, your Dependent child will be able to continue his insurance.

If events described in Section C should subsequently occur for your child who is born, adopted or placed for adoption as a newly acquired Dependent, coverage will be continued according to that section.

COBRA10

Requirements of Family and Medical Leave Act of 1993

Any provisions of the policy that provide for: (a) continuation of insurance during a leave of absence; and (b) reinstatement of insurance following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable:

A. Continuation of Health Insurance During Leave

Your health insurance will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health insurance during such leave must be paid, whether entirely by your Employer or in part by you and your Employer.

B. Reinstatement of Canceled Insurance Following Leave

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled insurance (health, life or disability) will be reinstated as of the date of your return.

You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any Pre-existing Condition Limitation to the extent that they had been satisfied prior to the start of such leave of absence.

Your Employer will give you detailed information about the Family and Medical Leave Act of 1993.

GM6000 TER5 TRM191V1

Benefits Extension

Dental Benefits Extension

An expense incurred in connection with a Dental Service that is completed after a person's benefits cease will be deemed to be incurred while he is insured if:

- for fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the prosthesis inserted within 3 calendar months after his insurance ceases.
- for a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- for root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

GM6000 BE6 BEX131V7

When You Have a Complaint or an Appeal

The following complies with federal law and is effective July 1, 2002. Provisions of the laws of your state may supersede.

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

Start with Member Services

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you can call the toll-free number on your Benefit Identification card explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You can also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you can start the appeals procedure.

Appeals Procedure

CG has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CG within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CG to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

Level One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, we will respond in writing with a decision within 30 calendar days after we receive an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

GM6000 APL262

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the committee will consult with at least one Dentist in the same or similar specialty as the care under consideration, as determined by CG's Dental reviewer. You may present your situation to the Committee in person or by conference call.

For level two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. The Committee review of your claim will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within five business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

GM6000 APL263

Independent Review Procedure

If you are not fully satisfied with the decision of CG's level two appeal review regarding your Medical Necessity or clinical appropriateness issue, you may request that your appeal be referred to an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by CG or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this Independent Review Process. CG will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by CG. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of CG level two appeal review denial. CG will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your condition, as determined by CG's Dentist reviewer, the review shall be completed within three days.

The Independent Review Program is a voluntary program arranged by CG.

GM6000 APL265

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (4) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring action under ERISA section 502(a); (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your plan may have other voluntary alternative

dispute resolution options such as Mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

If your plan is governed by ERISA, you have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against CG until you have completed the Level One and Level Two appeal processes. If your appeal is expedited, there is no need to complete the Level Two process prior to bringing legal action.

GM6000 APL266

ERISA Required Information

The name of the Plan is:

Brookhaven Science Associates, LLC Comprehensive Welfare Benefits Plan.

The name, address, ZIP code and business telephone number of the sponsor of the Plan is:

Brookhaven Science Associates, LLC.
P.O. Box 5000, Building 185
Upton, NY 11973
(800) 353-5321

Employer Identification Number (EIN)	Plan Number
113403915	501

The name, address, ZIP code and business telephone number of the Plan Administrator is:

Employer named above

The name, address and ZIP code of the person designated as agent for the service of legal process is:

Employer named above

The office designated to consider the appeal of denied claims is:

The CG Claim Office responsible for this Plan

The cost of the Plan is shared by the Employee and the Employer.

The Plan's fiscal year ends on 12/31.

The preceding pages set forth the eligibility requirements and benefits provided for you under this Plan.

ERISA31

Plan Type

The plan is a healthcare benefit plan.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine whether the Plan is maintained pursuant to one or more collective bargaining agreements and if a particular Employer is a sponsor. A copy is available for examination from the Plan Administrator upon written request.

Discretionary Authority

The Plan Administrator delegates to CG the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to CG the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

ERISA29 M

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No

consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) for any covered expenses incurred prior to the date that policy(s) terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) terminates will not be affected by the Plan termination. A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

ERISA15

Statement of Rights

As a participant in the plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements and copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each person under the Plan with a copy of this summary annual financial report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, your spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

ERISA39 M

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Enforce Your Rights

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied

or ignored, in whole or in part, you may file suit in a state or federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example if it finds your claim is frivolous.

ERISA20

Claim Determination Procedures Under ERISA

The following complies with federal law effective July 1, 2002. Provisions of the laws of your state may supersede.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be medically necessary to be covered under the plan. The procedures for determining medical necessity vary, according to the type of service or benefit requested, and the type of health plan.

You or your authorized representative (typically, your health care provider) must request medical necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not medically necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

Postservice Medical Necessity Determinations

When you or your representative requests payment for services that include a medical necessity determination, CG will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed. The determination period will be suspended on the date CG sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

GM6000 ERISA24

Procedures Regarding Claim Payment Determinations

Postservice Claim Determinations

When you or your representative requests payment for services which have been rendered, CG will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CG's control, CG will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you and your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date CG sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: 1. the specific reason or reasons for the adverse determination; 2. reference to the specific plan provisions on which the determination is based; 3. a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; 4. a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; 5. upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit; 6. in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

GM6000 ERISA25

Assistance with Your Questions

If you have questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan

Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CG will provide administrative services of the following nature: Claim Administration; Cost Containment; Financial; Banking and Billing Administration.

Benefits provided under this plan are self-insured by the Employer.

This document is issued by:

Connecticut General Life Insurance Company
900 Cottage Grove Road
Hartford, CT 06152

ERISA41

Definitions

Active Service

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time or part-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business;
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

DFS1 M

Coinsurance

The term Coinsurance means the percentage of charges for Covered Expenses that an insured person is required to pay under the Plan.

DFS17

Contracted Fee - CIGNA Dental Preferred Provider

The term Contracted Fee refers to the total compensation level that a provider has agreed to accept as payment for dental procedures and services performed on an Employee or Dependent, according to the Employee's dental benefit plan.

DFS1217

Dentist

The term Dentist means a person practicing dentistry or oral surgery within the scope of his license. It will also include a physician operating within the scope of his license when he performs any of the Dental Services described in the policy.

DFS24

Dependent

Dependents are:

- your lawful spouse ; and
- any unmarried child of yours who is:
  - less than 19 years old;
  - 19 or more years of age, enrolled in an accredited college or university as a full-time student and primarily supported by you;
  - 19 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to CG within 30 days after the date the child ceases to qualify above. During the next two years CG may, from time to time, require proof of the continuation of such condition and dependence. After that, CG may require proof no more than once a year.

A child includes a legally adopted child from the start of any waiting period prior to the finalization of the child's adoption.

Benefits for a Dependent child will continue until the last day of the calendar year in which the limiting age is reached.

DFS57 M DG

Employee

The term Employee means a full-time employee of the Employer. The term does not include employees who are temporary or who normally work less than 20 hours a week for the Employer.

DFS211 DG

Employer

The term Employer means the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CG is providing claim administration services.

DFS1595

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

DFS192

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

DFS149

Participating Provider - CIGNA Dental Preferred Provider

The term Participating Provider means a dentist, or a professional corporation, professional association, partnership, or other entity which has entered into a contract with CG to provide dental services at predetermined fees.

The providers qualifying as Participating Providers may change from time to time. A list of the current Participating Providers will be provided by your Employer.

DFS1218

Reasonable and Customary Charge

A charge will be considered Reasonable and Customary if:

- it is the normal charge made by the provider for a similar service or supply; and
- it does not exceed the normal charge made by most providers of such service or supply in the geographic area where the service is received, as determined by CG.

To determine if a charge is Reasonable and Customary, the nature and severity of the Injury or Sickness being treated will be considered.

DFS527

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